Testimony to the Human Services Committee

Presented by Mag Morelli, President, LeadingAge Connecticut

February 19, 2013

Regarding

House Bill 5069, An Act Reducing Health Care Fraud, Waste and Abuse

House Bill, 5106, An Act Concerning Charges for Patient Care by Nursing Homes

House Bill 6412, An Act Concerning Safe and Appropriate Transportation for Non-Ambulatory Medicaid Recipients

House Bill 6413, An Act Concerning Medicaid Eligibility and the Identification and Recovery of Assets

Good morning Senator Slossberg, Representative Abercrombie, and members of the Human Services Committee. My name is Mag Morelli and I am the President of LeadingAge Connecticut, a membership organization representing over one hundred and thirty mission-driven and not-for-profit provider organizations serving older adults throughout the continuum of long term care.

Our members are sponsored by religious, fraternal, community, and municipal organizations that are committed to providing quality care and services to their residents and clients. Our member organizations, many of which have served their communities for generations, are dedicated to expanding the world of possibilities for aging.

On behalf of LeadingAge Connecticut, I would like to testify on several bills before you today and thank the Committee for raising *House Bill 6413, An Act Concerning Medicaid Eligibility and the Identification and Recovery of Assets*. While I will address the specifics of this bill later in my testimony, I would like you to know that we are currently working in good faith with the legal community to address their concerns from last session and we consider the current language to be a work in progress.

House Bill 5069, An Act Reducing Health Care Fraud, Waste and Abuse

Fraud and abuse have no place within the health care system and should never be tolerated within the Medicaid program. As Medicaid providers, the members of LeadingAge Connecticut understand, accept and support the need to protect the integrity of the program through state oversight and audits.

We encourage efforts to ensure that the oversight and audit processes used by state government are both fair and balanced and are designed so as not to add unnecessary expense to the health care field. Therefore we do not object to the use of data analysis, as is proposed in this bill. We do, however, object to the manner in which the bill proposes to require a third party contractor.

Our concern with the bill is that The Department of Social Services would be required to enter into a contract with a third party entity to develop what amounts to be a basic data mining system, but which would include "contractor reimbursement and performance *guarantees* that ensure that savings generated by the implementation of such system exceed cost." Our experience with such third party audit contingency agreements is that they incentivize the contractor to cast a wide and often unsubstantiated net of accusations in an effort to negotiate down to a "settlement" amount. Such a practice places the investment of time and resources onto the provider who must prove the allegations to be false or exaggerated. We would hope that our own state resources would be able to conduct this basic data mining function and use it within existing audit efforts in a cost efficient manner that does not rely upon a third party whose profit incentives require overly aggressive business practices that cost law abiding providers more time and resources to refute.

The Committee should also be aware that long term care Medicaid and Medicare providers are already subject to the following government audit entities:
CERT: Comprehensive Error Rate Testing Program
DOJ: Department of Justice
DSS: DSS Office of Quality Assurance
HEAT: Health Care Fraud Prevention and Enforcement Action Team
MAC: Medicare Administrative Contractor
Medicaid RAC: State Medicaid Recovery Audit Contractor
Medicare RAC: Medicare Recovery Audit Contractor
MFCU: Medicaid Fraud Control Unit
MIC: Medicaid Integrity Contractor
OIG: Office of Inspector General
PERM: Payment Error Rate Measurement Program
ZPIC: Zone Program Integrity Contractor

LeadingAge Connecticut has previously called for oversight methods and audit practices that are fair, balanced, efficient and cost effective and which do not place unnecessary burdens on law abiding providers. We also urge the state to make sure that the audit standards, which consist of state Medicaid payment regulations and policy provisions, are updated and clarified. While oversight is imperative to maintaining the integrity of the Medicaid program, it should not add unnecessary costs and burdens to the system. Given limited resources, it is important that the state's audit efforts focus on areas and providers that pose a true risk of fraud, waste, abuse and errors. That is why we do not oppose the development of a fraud and detection system that utilizes data mining principles. What we <u>strongly object</u> to is the establishment of another contract with an outside entity that is incentivized to overestimate and therefore over burden the law abiding providers.

House Bill 5106, An Act Concerning Charges for Patient Care by Nursing Homes
The Department of Social Services (DSS) currently pays nursing homes cost based per diem rates for caring for Medicaid-eligible residents. The rates are facility specific and are calculated by the state based on the documented costs of caring for residents. The calculation utilizes what the state has determined to be "allowable" costs and the calculations are further restricted by state established limits or caps on certain cost components. The rate setting calculation is very supportive of direct care costs and the direct care cost cap is much higher than other cost categories. The following link is to a 2012 OLR report that provides an overview of the rate setting system: http://www.cga.ct.gov/2012/rpt/2012-R-0401.htm

In theory, the current statutory rate setting system is very good and encourages strong staffing levels and high quality care. However, the statutory framework is ignored by the state on an ongoing basis and has been replaced by either rate freezes or small percentage increases. As a result, nursing homes are currently paid well below their calculated rates which are already lower than their actual costs.

The proposed bill references acuity levels. The level of acuity in the nursing home is rising and as the state continues to encourage the rebalancing of the long term care system and reduce the number of nursing home beds, the acuity level of nursing home residents will rise even higher. So if the intent of this legislation is to redesign the current rate setting system to enhance nursing home payments to ensure the provision of high quality care to a higher acuity population, then we would support the concept. ***However,*** **if the intent is as stated in the purpose of the bill, which is "to reduce the state's overall Medicaid costs," then we strongly object.** The reduction of nursing home rates would only serve to lower the quality of nursing home care at a time when resident care needs are rising. **We encourage the Committee to reject this purpose.**

Quality aging services – whether they are provided in the community or in the nursing home – cannot be sustained without rates of reimbursement that cover the cost of care. Without adequate reimbursement, a balanced system of long term care will fail to thrive and long standing, high quality providers will be lost. While understanding the current fiscal situation, we cannot sustain cuts to our Medicaid rates of reimbursement and we urge the state to remain committed to the current path we are on and to continue to invest in the restructuring of our Medicaid system so that we can provide our most frail elderly with the care they need in the place they call home.

House Bill 6412, An Act Concerning Safe and Appropriate Transportation for Non-Ambulatory Medicaid Recipients
LeadingAge Connecticut is very concerned about how the recently enacted requirements for the use of "stretcher vans" will affect patient and resident care. It is hard for us to evaluate the stretcher van mode of transportation as we are not familiar with this type of vehicle and we understand that no such vehicle exists currently in the state. We assume that the Committee has raised this bill to provide more time to review and carefully reconsider this concept and we would support that effort. The transportation of frail, elderly persons must be done in a safe and proper manner and we encourage the Committee to consider this as you reevaluate this requirement.

House Bill 6413, An Act Concerning Medicaid Eligibility and the Identification and Recovery of Assets

LeadingAge Connecticut would like to thank the Committee for raising this bill which proposes to address the financial and administrative burdens placed on nursing home providers when a Medicaid penalty period is imposed on a nursing home resident due to the misappropriation of an asset. The bill also seeks to assist in the collection of applied income, as well as to place a common sense provision into the eligibility process regarding life insurance policies.

The bill before you today is the final amended version of a bill that last year passed the Senate, but which never received a vote in the House. There was some opposition to the bill last year and we are currently working with the groups who opposed it in an attempt to find language that we can all agree upon. We appreciate the Committee raising this bill and allowing us the opportunity to continue to work toward final language.

As a representative of the non-profit nursing homes, we would like to see this legislation address three specific issues:

1. The first is to provide the nursing home with additional statutory authority to pursue recovery when there is an intentional transfer or theft of an asset that causes the Department of Social Services to impose a penalty period.
2. The second is to provide the nursing home with additional statutory authority to pursue recovery when the applied income of a nursing home resident is being withheld or is misappropriated and not paid to the nursing home as required.
3. The third is to prevent the existence of a small insurance policy from delaying the eligibility the process.

We believe that modifying the law to strengthen the nursing home's ability to recover misappropriated assets and applied income will not only assist nursing homes, but will also promote the use of private resources to pay for nursing home care rather than encouraging a reliance on Medicaid funding. It is important to send a message that you cannot steal or transfer a person's assets or income and then expect the state or the nursing home to pay for that person's nursing home care. That is not what Title 19 was created for and it is not what we should be encouraging as a state.

Intentionally Transferred Assets

Most nursing home residents are not admitted to the nursing home as Medicaid recipients. The typical resident spends down his or her assets by paying for their nursing home care before applying for Medicaid. Once the resident applies, the state conducts a five year look back as part of the eligibility process. If a determination is made by the state that within the look back period, the resident *intentionally and inappropriately* transferred assets *so as to qualify for Medicaid*, the state will impose a **penalty period** on the nursing home resident.

During a penalty period, Medicaid will not pay for a nursing home resident's care. The length of a penalty period is calculated to be equal to the amount of the transferred asset. A $100,000 transferred asset is calculated into a penalty period equal to $100,000 of nursing home care. The resident remains in the nursing home for that amount of time, **but**

with no source of payment. In these cases, it is impossible for the facility to discharge the resident as no other facility will accept the resident under these circumstances. The nursing home must provide the care without any payment.

As an example, one member nursing home was notified in 2010 that one of its residents intentionally transferred $700,000 and therefore was placed into a penalty period that will last until 2016. That nursing home is now expected to provide skilled care to that resident until 2016 without any payment.

Nursing homes cannot afford to provide these extended periods of uncompensated care to residents who have purposely given away their private assets to avoid paying for their nursing home care or to residents who have had their assets stolen by relatives or acquaintances.

This is not an issue for resident who *unintentionally* gift assets – only for those who do so with the intention of avoiding payment for the nursing home care. Those who have transferred assets unintentionally are allowed to apply to the Department of Social Services for a hardship waiver of the penalty period. There is also a hardship waiver for residents suffering from dementia. Unfortunately, the nursing home itself is not allowed to apply for a hardship waiver.

Nursing homes are the only providers in the continuum that are required to provide this level of uncompensated care during Medicaid penalty periods. Moreover, nursing homes bear the sole burden of pursuing recovery of the missing or transferred asset in order to get paid for the care they provide. We are asking for this bill to assist us in that recovery effort.

While we would prefer legislation which would provide nursing homes with state payments during extended Medicaid penalty periods, we know that the state will not agree to this solution. Therefore we are proposing an independent statute that would create a liability owed to the nursing home by the person(s) who willfully transferred or received an asset so as to avoid payment of that asset to the nursing home. It is our intent that such legislation would assist the nursing home in pursuing collection of the willfully transferred asset.

Withheld Payment of Applied Income

When a nursing home resident is granted Medicaid, there is a calculated amount of the resident's own income (social security, pension, etc.) that must be used to pay for nursing home care. This is what is referred to as "applied income" and the amount is calculated by the Department of Social Services. The amount that a nursing home receives in its Medicaid rate for a resident's care is reduced by the calculated amount of applied income. It is the responsibility of the nursing home, not the state, to actually collect the applied income.

While applied income is required to be paid to the nursing home as a condition of Medicaid eligibility, it is occasionally withheld by a family member, acquaintance or the resident. It is then the nursing home's responsibility and burden to seek recovery. We are therefore seeking statutory authority to assist the nursing homes' efforts to collect the

applied income by allowing a nursing home to pursue civil action to collect withheld applied income payments.

Addressing Life Insurance Policies in the Eligibility Process

A nursing home resident is deemed eligible for Medicaid once his or her assets are spent down to less than $1,600. If a Medicaid applicant's assets exceed the $1,600 limit, the asset causing the resident to go over the limit it is considered a "disqualifying asset" and the applicant is not eligible for Medicaid during the month in which the resident possessed the disqualifying asset. The difficulty occurs when a single disqualifying asset is not discovered right away or cannot be easily liquidated and serves to deem the applicant ineligible for several months. A simple example would be if you applied for Medicaid in January and it was discovered months later in June that you possessed a $2,000 disqualifying asset, then that $2,000 asset disqualified you in January, in February, in March, in April, in May, and then in June. Six months of ineligibility because of a single $2,000 asset and the *nursing home will not be paid for any of those months of care provided.*

The delays in processing Medicaid applications have exacerbated this problem. Medicaid applicants are being deemed ineligible for several months due to the *delayed discovery* of a single disqualifying asset that triggers ineligibility for all the months the application sat pending in the state office. Similarly, single disqualifying assets that are difficult to liquidate, such as small life insurance policies, have historically caused distressing eligibility situations and months of uncompensated care.

This proposed legislation inserts one new common sense rule into the eligibility process so that a person would not be deemed "over assets" based solely on a small life insurance policy of $10,000 or less. The language in this bill would allow time for the life insurance policy to be cashed out and paid to the facility without holding up the eligibility process. While this seems small, this would be a great help to residents and nursing homes that are currently frustrated by this situation.

Again, we thank the Committee for raising this bill and addressing these crucial issues.

Thank you for this opportunity to provide this testimony and I would be happy to answer any questions.

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